Introduction

Prior authorization (PA) is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require PA and some may begin prior to requesting authorization.

Purpose of Prior Authorization

The purpose of prior authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Prior authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Prior authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Prior authorization is performed by DMAS or by a contracted entity.

General Information Regarding Prior Authorization

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for PA requests. The PA entity will approve, pend, reject, or deny all completed PA requests. Requests that are pended or denied for not meeting medical criteria are automatically sent to medical staff for review. When a final disposition is reached the PA entity notifies the individual and the provider in writing of the status of the request. If the decision is to deny, reduce, terminate, delay, or suspend a covered service, written notice will identify the recipient's right to appeal the denial, in accordance with 42 CFR §200 *et seq* and 12 VAC 30-110 *et seq*. The provider also has the right to appeal adverse decisions to the Department.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care program, the PA entity is able to receive monthly information from and provide monthly information to the Medicaid managed care organizations (MCO) or their subcontractors on services previously authorized. The PA entity will honor the Medicaid MCO prior authorization for services and have system capabilities to accept PAs from the Medicaid MCOs.

Communication

Provider manuals are posted on the DMAS and contractor's websites. The contractor's website outlines the services that require PA, workflow processes, criterion utilized to make decisions, contact names and phone numbers within their organization, information on grievance and appeal processes and questions and answers to frequently asked questions. The PA entity provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing. Updates or changes to the PA process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the manual.

APPEALS

Denial of prior authorization for services not yet rendered may be appealed in writing by the Medicaid recipient within 30 days of the written notification of denial. If the PA denial is for a service that has already been rendered and the issue is whether DMAS will reimburse the provider of the services already provided, the provider may appeal the denial in writing within 30 days of the written notification of denial. Send all written appeals to:

Director, Appeals Division Department of Medical Assistance Services
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

The provider may not bill the recipient for covered services that have been provided and subsequently denied by DMAS.

Prior Authorization Process

Effective August 1, 2003, the Department of Medical Assistance Services (DMAS) implemented a mandatory prior authorization process for all non-emergency, planned and scheduled, outpatient Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiograph (MRA), Computerized Axial Tomography (CAT), and Positron Emission Tomography (PET) scans. These prior authorization requirements apply for all Medicaid clients enrolled in fee-for-service, for the Medallion programs, as well as FAMIS clients enrolled in fee-for-service or Primary Care Case Management (PCCM) programs and must be completed prior to the scan being performed. These requirements do not apply to these scans when performed during an inpatient hospitalization or as an emergency through the hospital's emergency room. The following information outlines the

procedures for obtaining prior authorization and reimbursement for these non-emergency, outpatient scans.

DMAS has contracted with the KePRO to conduct medical appropriateness reviews utilizing InterQual ISX criteria, a McKesson Health Solutions, LLC product. To request prior authorization, contact KePRO. KePRO will accept requests via direct data entry (DDE), by facsimile, phone, or US Mail. The preferred method is through DDE for a quicker response. Specific information regarding the prior authorization requirements and methods of submission can be found at the contractor's website, DMAS.KePRO.org. Click on Virginia Medicaid. They may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329. The program will take you through the steps needed to receive authorization for service request.

It is the responsibility of the ordering physician or his/her representative, the hospital or outpatient facility or radiologist to contact KePRO and provide the necessary information and medical appropriate indications for the specific type of scan being ordered.

Upon receipt of the case, a reviewer will reassess the information against InterQual® ISX (Indications for Imaging Studies and X-rays) criteria. If the case information satisfies the criteria, an approval is given for the requested diagnostic test. If the documentation submitted does not satisfy the criteria, a referral will be made to a peer reviewer for the determination.

If the patient has Medicare Part B, preauthorization is not required unless Medicare has been billed and denied. When this occurs, the ordering physician or his/her representative, the hospital or outpatient facility or radiologist must contact KePRO for retrospective authorization. Likewise, if the patient has been determined to be eligible for Medicaid covered services retrospectively, and his/her coverage is made retroactive to include the scanning date of service, the ordering physician or his/her representative, the hospital or outpatient facility or radiologist must contact KePRO for retrospective authorization. For recipients with other third party coverage (other than Medicare), the ordering physician or his/her representative, the hospital or outpatient facility or radiologist must contact KePRO prior to the scan for a prior authorization. There will be no retrospective reviews done for recipients with other third party coverage since the prior authorization from Medicaid is to occur before the scan is done.

Also, urgent scans that are performed prior to obtaining preauthorization must be retrospectively authorized. The definition of an urgent scan is when the ordering physician identifies an urgent need to have a scan performed the same day as seen by the physician. The physician sends the patient immediately to the hospital or outpatient facility to have the scan performed. The ordering physician or his/her representative, the hospital or outpatient facility or radiologist must contact KePRO for retrospective

authorization within one business day of the scan being performed. When contacting KePRO to perform retrospective review, notify KePRO that Medicare Part B has been denied, or that the patient has retroactive eligibility, or that the scan was performed on an urgent basis and provide the necessary information and medical appropriateness indications for the scan that has already been performed.